MAKING MEDICAL CARE FIT CHRONIC DISEASE

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THE HEALTH CARE CRISIS

1. Quality of Care

   45% of care episodes below standard.

2. Access to Care

   45 million uninsured and benefits declining for the insured.

3. Cost of Care

   Costs rising at 1.7 times the rate of the gross domestic product.

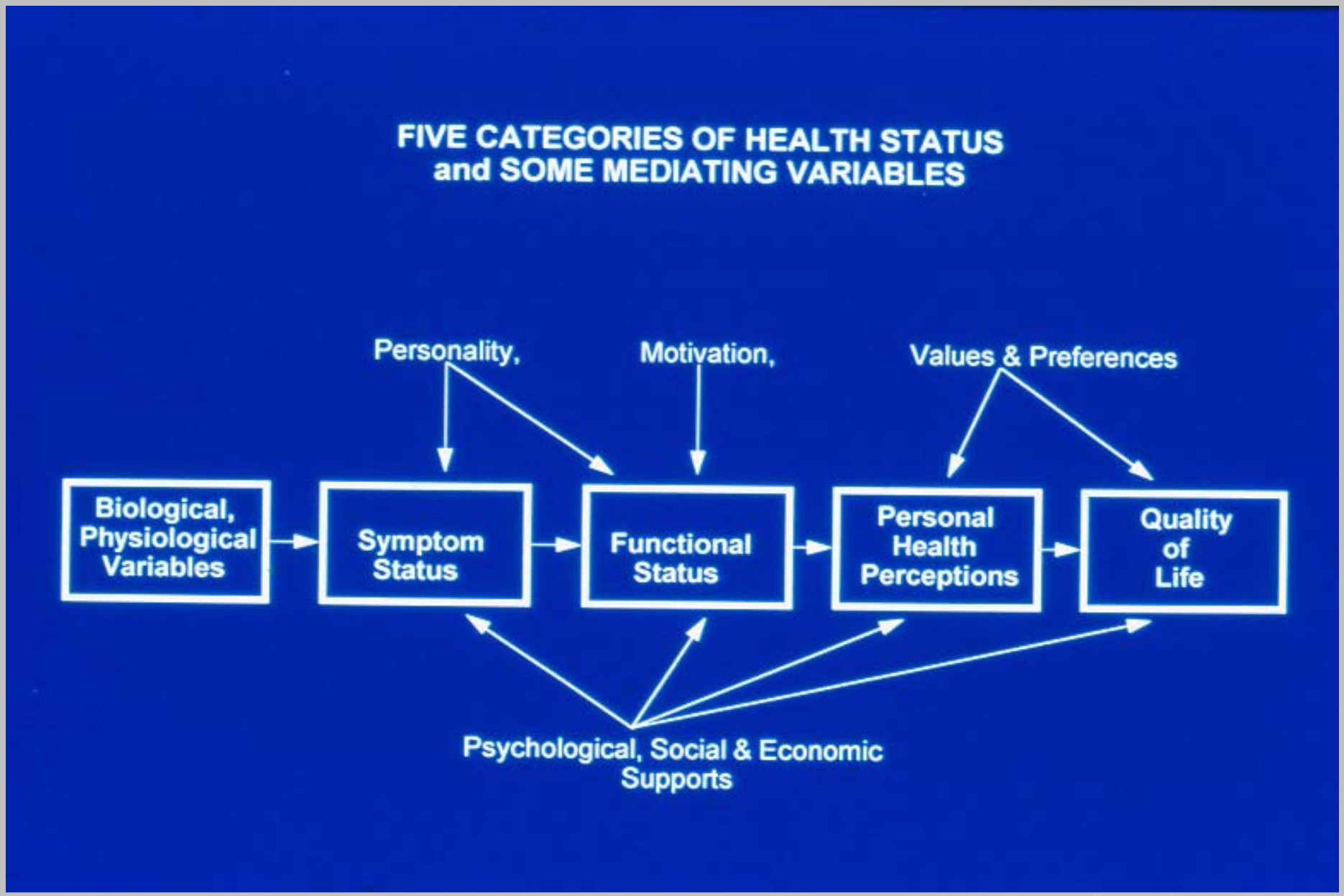
CHRONIC DISEASE

In the United States, chronic disease is:

1. The main cause of disability.
2. The principal reason for use of health services.
3. Responsible for approximately 78% of health care expenditures.

Consequences of Chronic Disease for the Patient

- Persistent symptoms; no cure
- Continuous medication use
- Behavior change (e.g., diet, exercise, leisure)
- Changed social and work circumstances
- Emotional distress
- Responsibility to interpret effects of the disease and treatment (e.g. trends, pace of change, consequences)
- Responsibility to participate in decisions.



Wilson & Cleary 1995

WHAT DO PATIENTS WANT?

1. Access to information concerning:
    - diagnosis and its implications
    - available treatments and their consequences
    - potential impact on patient's future
2. Continuity of care and ready access to it.
3. Coordination of care, particularly with specialists.
4. Infrastructure improvements (scheduling, wait times, billing, prompt care).

WHAT DO PATIENTS WANT?

5. Ways to cope with symptoms such as pain, fatigue and disability.

6. Ways to adjust to disease consequences such as uncertainty, fear, depression, loss of independence, anger, loneliness, sleep disorders, memory loss, exercise needs, nocturia, sexual dysfunction and stress.

Johns Hopkins U.S. Physician Survey – 2001

Reported that training did not prepare them to:

1. Educate patients with chronic conditions (66%).
2. Coordinate in-home and community services (66%).
3. Provide end of life care (65%).
4. Manage geriatric syndromes (65%).
5. Manage psychological and social aspects of chronic care (64%).

Johns Hopkins U.S. Physician Survey – 2001 (cont'd)

Reported that training did not prepare them to:

6. Manage chronic pain (63%).
7. Assess caregiver and family needs (63%).
8. Provide nutritional advice (63%).
9. Develop teamwork with non-physician care providers (61%).

CALIFORNIA REGION
COST, UTILIZATION AND QUALITY RATIOS

	LA	SF	SAC
Last 2 years of Life			
Expense	1.69	1.32	1
Bed Use	1.61	1.20	1
ICU Use	2.28	1.17	1
Specialty Care	2.45	1.26	1
Last 6 months of Life			
Bed Use	1.62	1.19	1
ICU Use	2.31	1.16	1
Specialty Care	3.33	1.42	1

Wennberg 2005

CALIFORNIA REGION
COST, UTILIZATION AND QUALITY RATIOS

	LA	SF	SAC
Summary Medical Scores			
AMI	0.96	1.00	1
CHF	0.93	1.01	1
Pneumonia	0.80	0.98	1
Patient Rating of Hospitals			
% Below CA Average	57	9	13
% Above CA Average	7	32	25

Wennberg 2005

Chronic Disease Requires a Different Practice of Medicine

1. The nature of care changes.
    - The goal is function and comfort, not cure.
    - Care is an unfolding, undulating, multivariate management process over time.
    - Continuity and integration of care are central.
    - Care is often best provided by a team that includes the patient.
    - Management goals are established with the patient and family.

Chronic Disease Requires a Different Practice of Medicine

2. The role of the patient changes.

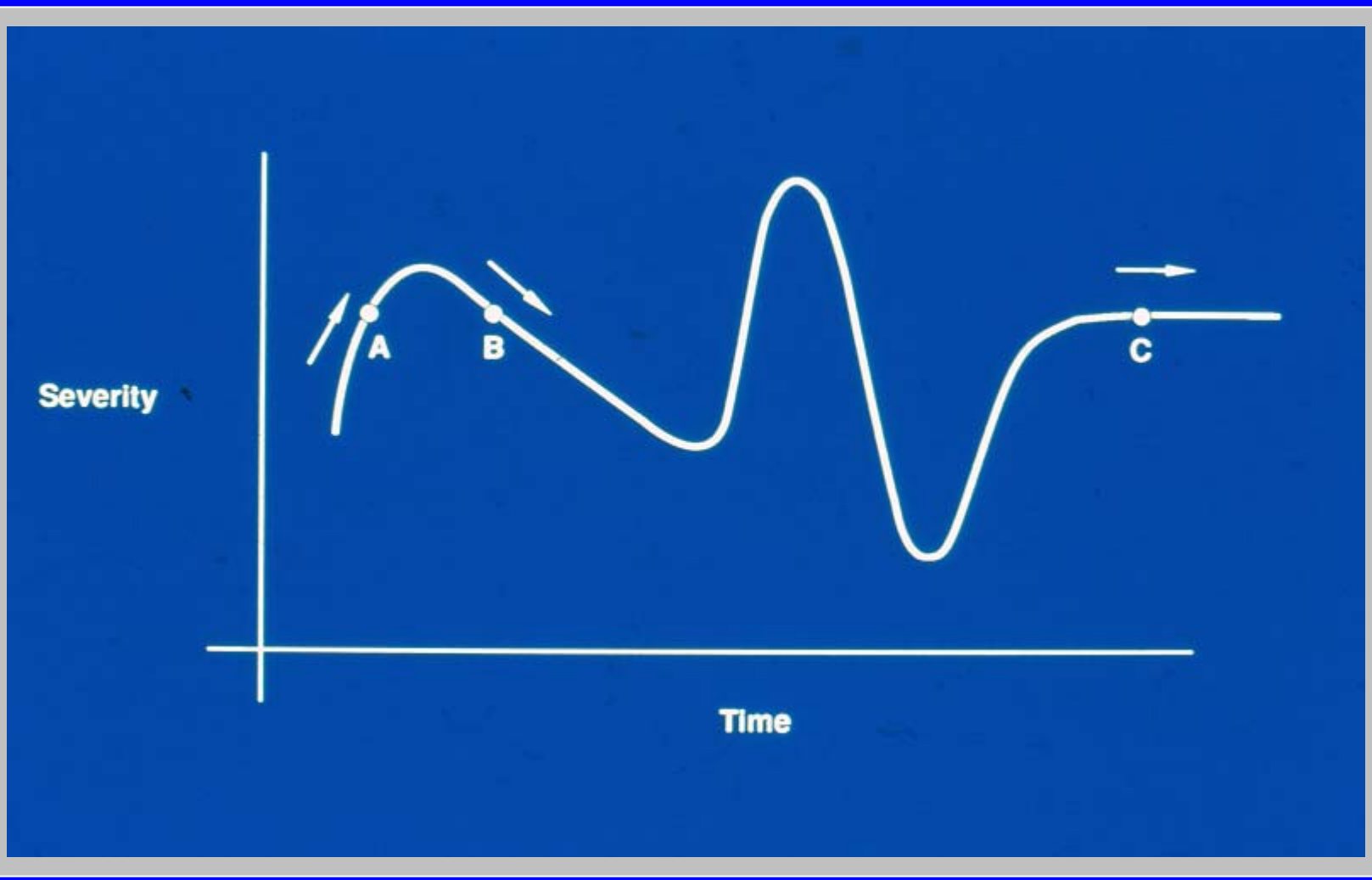
- Many new responsibilities
  - medication adherence
  - behavior change
  - life activity change
  - family adaptation
  - emotional adjustment
  - treatment impact assessment
- New skills to be learned
- Now a principal caregiver.

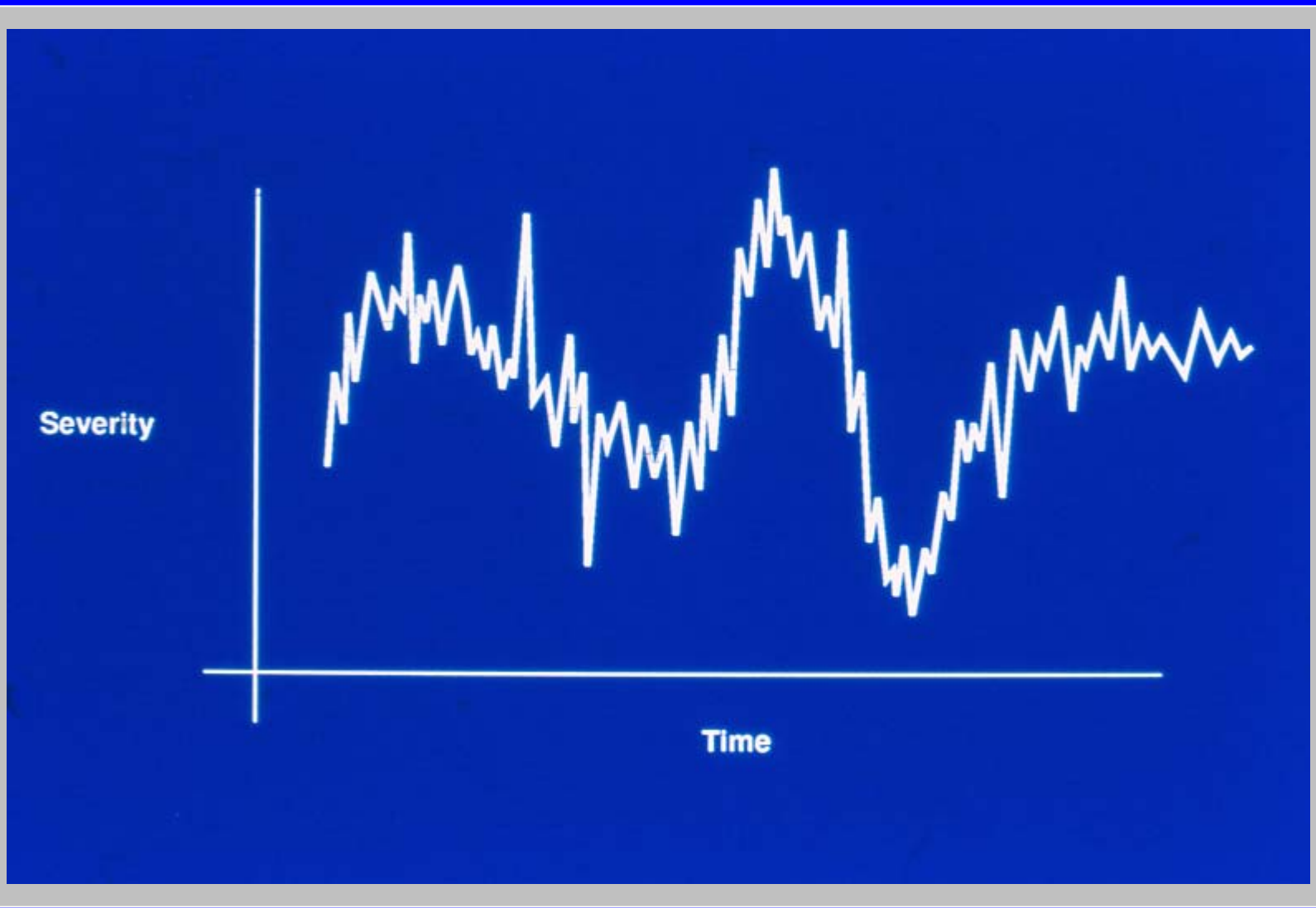
Chronic Disease Requires a Different Practice of Medicine

3. The role of the physician changes.
   - Responds to disease/illness trajectory
   - Assures continuity and integration of care
   - Organizes the health care team
   - Arranges learning by the patient
   - Shares decision authority with the patient and other health professionals.
   - Adapts care to the impact of the illness on the patient.

Chronic Disease Requires a Different Practice of Medicine

4. The sites of care change
   - Home or community sites are frequently the best sites for care.
   - Care is often very effective by telephone, email or monitor systems.
5. The physician-patient relationship becomes a partnership.
   - Each brings complementary knowledge and has reciprocal responsibilities.


Severity
A
B
C
Time


Severity
Time

WILL THESE APPROACHES WORK?

The evidence is favorable:

1. Continuity and integration
2. The knowledgeable patient
    - Self-management, group visits, late-onset diabetes.
3. The collaborating physician
    - Compliance, patient-centered care, MOS.

CDSMP
WHAT IS TAUGHT?

1. Disease-related problem solving (e.g., interpreting symptoms, maintaining activities).
2. Managing medications (e.g., adherence, adversities, barriers).
3. Cognitive symptom management (e.g., relaxation, distraction, reframing).

CDSMP
WHAT IS TAUGHT?

4. Exercise
5. Managing emotions (e.g., emotions as symptoms, fear, self-doubt).
6. Communication skills (e.g., building partnership with physicians).
7. Use of community resources.

CDSMP
HOW IT IS TAUGHT?

- Highly interactive between leaders and participants.
- Strategies to build skills and confidence.

1. Modeling (e.g., lay leaders have disease).
2. Reframing (e.g., different causes of symptoms).
3. Persuasion (e.g., explanation, setting group norms).
4. Skills mastery (e.g., weekly action plans).

Results of Patient Learning

Outcome	Self-management Course (ASMP) 4 years later	Group Visits (CHCC) 2 years later
	N = 401	N = 793
Pain	– 20%	
Disability	+ 9%	
Amb. Visits	– 44%	
ADL Loss		– 58%
Satisfaction		+ 8%
Hospitalizations		– 19%

HOW SELF-MANAGEMENT EDUCATION WORKS

- Mastering new skills through action plan trials.
- Learning from other patients.
- Enhancing perceived self-efficacy.

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WILL THESE APPROACHES WORK?

The evidence is favorable:

4. Success of different practice modes
    - Telephone, area variation, VA, anticoagulation.

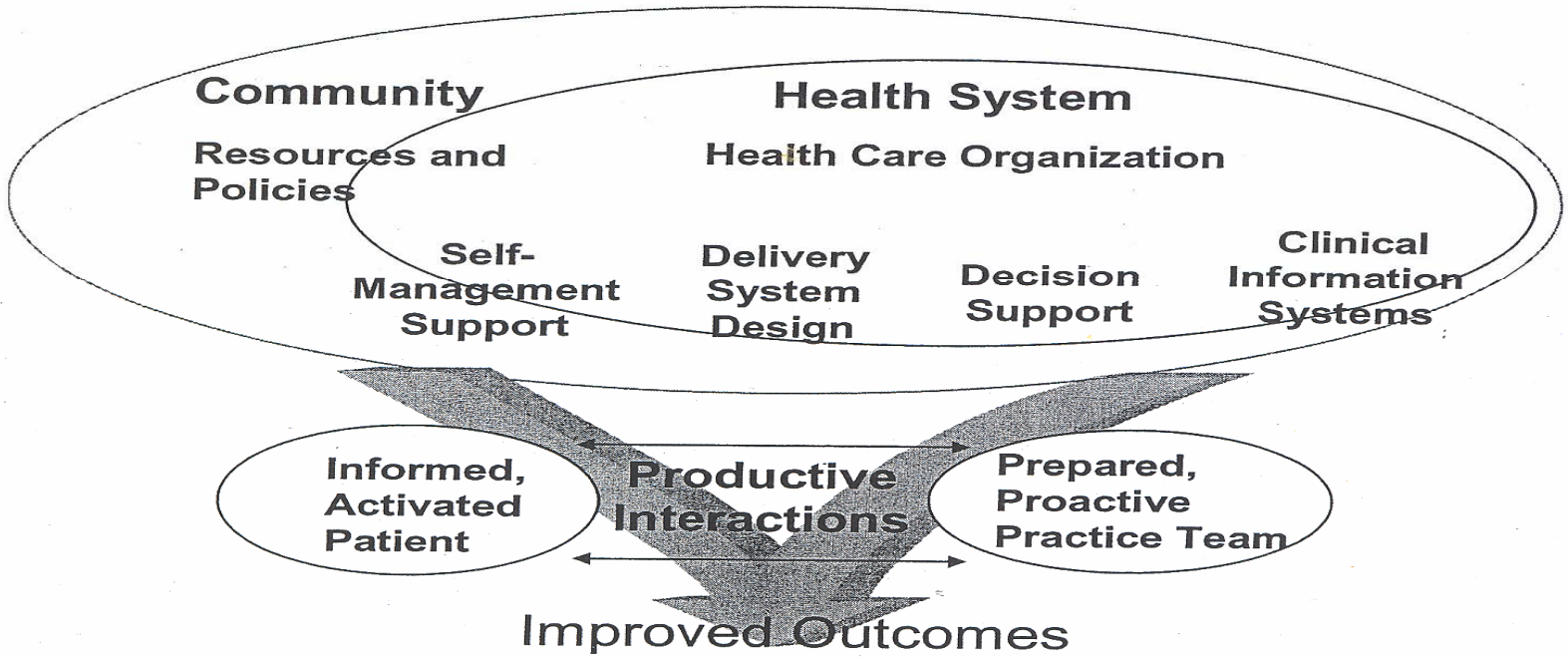
5. Design of specific service structures
    - Chronic Care Model, PBGH-BCCP

California Cooperative Healthcare Reporting Initiative

Diabetes & Cardiovascular Care Collaborative

Change Package

Chronic Care Model



EFFECTIVE AND EFFICIENT CARE OF PATIENTS WITH CHRONIC DISEASE

Practice Components

1. Registry of patients to invite and monitor participation in management plans.
2. Planned visits by patients to prepare individual management plans.
3. An action plan developed with each patient, including responsibilities for different members of the team.
4. Access to patient self-management education programs.

EFFECTIVE AND EFFICIENT CARE OF PATIENTS WITH CHRONIC DISEASE

5. Group visits of patients with the physician and selected staff members in which the interests and concerns of each are raised and mutual learning occurs.
6. Remote management capabilities (telephone, e-mail, home monitors).
7. Case management with remote communication based in the team office.
8. An electronic medical record to assure continuity and integration of care.

ADVANTAGES

1. Focuses on the interaction of the patient, physician and other health professionals which is the heart of medical care.

2. Achievable within existing health care structures. Requires changed understanding and behaviors, not new construction or expensive technologies.

3. Fits the need to derive health care improvements and health policy from the experience of practice.

ADVANTAGES

4. By focusing on effectiveness and efficiency in medical practice, it has the potential for major savings in health care costs.
5. Compatible with different types of health care funding and insurance.
6. Facilitates acute disease care.
7. Enhances satisfaction of patients and health professionals.